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No. 91-732

In The

Supreme Court of the United States

October Term, 1991

KAREN SNIDER, Acting Secretary
of the Department of Public Welfare,
Commonwealth of Pennsylvania, et al.,

Petitioners,

v.

TEMPLE UNIVERSITY – OF THE COMMONWEALTH
SYSTEM OF HIGHER EDUCATION, et al.,

Respondents.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

BRIEF IN OPPOSITION OF RESPONDENT TEMPLE UNIVERSITY – OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION

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QUESTIONS PRESENTED

1. Whether a hospital has a private cause of action under 42 U.S.C. § 1983 to compel State officers to comply with two requirements of the Medicaid Act for payment rates for inpatient hospital care:

> (a) the requirement of 42 U.S.C. § 1396a(a)(13)(A) and 42 U.S.C. § 1396r-4 that States take into account the situation of hospitals serving a disproportionate share of indigent patients; and
>
> (b) the requirement of 42 U.S.C. § 1396a(a)(13)(A) that rates be reasonable and adequate to meet the costs of efficiently and economically operated hospitals.

2. Whether a State can comply with the "disproportionate share" hospital requirement of the Medicaid Act by increasing its payments up to a maximum of 2.5% when that State's data establish that hospitals with the largest indigent patient loads have costs more than 16% higher than otherwise comparable hospitals.

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ADDITIONAL STATUTORY PROVISIONS INVOLVED

The Petition omits significant portions of 42 U.S.C. § 1396r-4 involved in this case. That Section reads in relevant part as follows:

(a) IMPLEMENTATION OF REQUIREMENT

(1) A State plan under this subchapter shall not be considered to meet the requirement of section 1396a(a)(13)(A) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that –

> (A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) of this section, which meets the requirement of subsection (d) of this section), and
>
> (B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c) of this section.

* * *

(4) The requirement of this subsection may not be waived under section 1396n(b)(4) of this title.

(b) HOSPITALS DEEMED DISPROPORTIONATE SHARE

(1) For purposes of subsection (a)(1) of this section, a hospital which meets the requirement of subsection (d) of this section is deemed to be a disproportionate share hospital if –

(A) the hospital's medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State; or

(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent.

* * *

(c) PAYMENT ADJUSTMENT

In order to be consistent with this subsection, a payment adjustment for a disproportionate share hospital must either –

(1) be in an amount equal to at least the product of (A) the amount paid under the State plan to the hospital for operating costs for inpatient hospital services (of the kind described in section 1395ww(a)(4) of this title), and (B) the hospital's disproportionate share adjustment percentage (established under section 1395ww(d)(5)(F)(iv) of this title);

(2) provide for a minimum specified additional payment amount (or increased percentage payment) and (without regard to whether the hospital is described in

subparagraph (A) or (B) of subsection (b)(1) of this section) for an increase in such a payment amount (or percentage payment) in proportion to the percentage by which the hospital's medicaid utilization rate (as defined in subsection (b)(2) of this section) exceeds one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State or the hospital's low-income utilization rate (as defined in subsection (b)(3) of this section); or

(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that –

(A) applies equally to all hospitals of each type; and

(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this subchapter or to low-income patients.

Respondent Temple University – of the Commonwealth System of Higher Education[1] ("Temple") respectfully requests that this Court deny the Petition for Writ of Certiorari seeking review of the Third Circuit's decision.[2] That decision is reported at 941 F.2d 201 (1991).

COUNTERSTATEMENT OF THE CASE

1. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, 1396a-1396u (the "Medicaid Act") provides federal financial participation for payments under State Medicaid programs that comply with that Act. Prior to 1981, the Medicaid Act required States to pay hospitals for inpatient care on the basis of the hospitals' reasonable costs. In 1981, Congress extended to hospitals what is commonly called the Boren Amendment. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2173,

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[1] Temple is a Pennsylvania non-profit corporation which has been legislatively designated as state-related but which operates independently of state government under the direction of its board of trustees. 24 Pa. Cons. Stat. Ann. §§ 2510-1 to 12 (Supp. 1991). Temple has no subsidiaries that are not wholly-owned and no parent corporation.

[2] The five actions before this Court on the Petition are *Temple University – Of the Commonwealth System of Higher Education v. White, et al.*, Nos. 90-1112 and 90-1244 (3d Cir.) and C.A. 88-6646 (E.D. Pa.); *Frankford Hospital v. White, et al.*, No. 90-1204 (3d Cir.) and C.A. 88-08927 (E.D. Pa.); *Albert Einstein Medical Center, et al. v. White, et al.*, No. 90-1203 (3d Cir.) and C.A. 88-08831 (E.D. Pa.); *Hahnemann University Hospital, et al. v. White, et al.*, No. 90-1205 (3d Cir.) and C.A. 88-09132 (E.D. Pa.); and *Hospital Association of Pennsylvania, et al. v. White, et al.*, No. 90-1206 (3d Cir.) and C.A. 88-09848 (E.D. Pa.).

95 Stat. 357, 808-09 (1981) (codified at 42 U.S.C. § 1396a(a)(13)(A)). The actions before this Court involve two requirements of the Medicaid Act, as modified by the Boren Amendment: (1) payment rates for inpatient care must "take into account the situation of hospitals that serve a disproportionate number of low income patients with special needs," and (2) a State must find and make assurances to the Secretary of Health and Human Services that those rates are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 U.S.C. §§ 1396a(a)(13)(A), 1396r-4. The House Conference Report for the Boren Amendment described both of these requirements but emphasized the requirement relating to "disproportionate share" hospitals by noting their "atypical costs" and then stating:

> The conferees recognize that public hospitals and teaching hospitals which serve a large Medicaid and low income population are particularly dependent on Medicaid reimbursement, and are concerned that a State take into account the special situation that exists in these institutions in developing their rates.

H.R. Conf. Rep. No. 208, 97th Cong., 1st Sess. 962 (1981), *reprinted in* 1981 U.S.C.C.A.N. 1, 1324.[3]

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[3] In later enacting section 1396r-4, the House Budget Committee described Congressional concern for hospitals with high Medicaid volumes in similar terms:

> The purpose of this requirement . . . was to assure that, precisely because States were given flexibility in establishing payment rates, that those payment

(Continued on following page)

The "disproportionate share" hospital requirement has been the subject of Congressional action on six occasions since it was enacted in 1981. In 1985, Congress required the Secretary of Health and Human Services to provide a report on the methods used by States for their compliance with this requirement. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9519, 100 Stat. 82, 216-17 (1986).[4] After the Secretary submitted that report, the House Budget Committee concluded that there had been a "startling record of noncompliance [reflecting] the indifference, if not hostility, of HCFA and many of the States to the 1981 statutory

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(Continued from previous page)

> rates at a minimum meet the needs of those facilities which, because they do not discriminate in admissions against patients based on source of payment or on ability to pay, serve a large number of Medicaid-eligible and uninsured patients who other providers view as financially undesirable. These "disproportionate share" hospitals are an essential element of the Nation's health care delivery system, and the Federal and State governments, through the Medicaid program, have an obligation to assure that payment levels assist these facilities in surviving the financial consequences of competition in the health care marketplace.

H.R. Rep. No. 391(I), 100th Cong., 1st Sess. 524 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1, 2313-344.

[4] In the interim, the Health Care Financing Administration attempted to challenge a generous disproportionate share adjustment proposed by Georgia. Congress responded in 1986 by clarifying that HCFA has no authority to limit the payment adjustments to disproportionate share hospitals. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9433, 100 Stat. 1874, 2068 (1986) (codified at 42 U.S.C. § 1396a(h)).

requirement [for 'disproportionate share' hospitals]."[5] As a result, Congress amplified that requirement by enacting Section 1396r-4, which became effective July 1, 1988. Section 1396r-4 had two important requirements. First, the Section defined "disproportionate share" hospitals as including at least those hospitals at least one standard deviation above the mean Medicaid inpatient utilization rate and those hospitals with low-income utilization rates of greater than twenty-five percent. A state might classify more hospitals as "disproportionate share," but it could not classify fewer. 42 U.S.C. § 1396r-4(a)(1), (b). Second, a State was required to make "appropriate increases" in payments to "disproportionate share" hospitals using either (a) the formula used for Medicare reimbursement, or (b) a formula which the State developed providing for a minimum payment (or increased percentage payment) as well as an increase in that payment or percentage "in proportion to the percentage by which the hospital's medicaid utilization rate . . . exceeds one standard deviation above the statewide mean." 42 U.S.C. § 1396r-4(a)(2), (c). The House Budget Committee described what it had in mind if a State elected not to use the Medicare formula:

> The Tennessee approach offers an example of what the Committee intends for an alternative payment adjustment. In Tennessee, disproportionate share hospitals are defined by volume. For every 1,000 Medicaid days over 4,000 Medicaid patient days, hospitals receive a 6 percent increase in their payment rate for inpatient services, up to a maximum increase of 34 percent.

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[5] H.R. Rep. No. 391(I), 100th Cong., 1st Sess. 525 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1, 2313-345.

H.R. Rep. No. 391(I), 100th Cong., 1st Sess. 526 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1, 2313-346.

Section 1396r-4 has been amended three times since 1987. Most recently, the 1990 amendment added Section 1396r-4(c)(3), which permits a State, if it chooses, to vary its "disproportionate share" payments for different hospital types and to have an adjustment "that is reasonably related to the costs, volume, or proportion of services provided to [Medicaid] patients." Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4703, 104 Stat. 1388-171 (1990) (codified at 42 U.S.C. § 1396r-4(c)(3)).[6]

Clarification of the "disproportionate share" hospital requirement continues to the present time. On October 31, 1991 (three days after the Petition was filed), HCFA published an interim final regulation which would limit the number of hospitals that States could classify as qualifying for "disproportionate share" payments. In its published notice, HCFA stated its intention to publish soon still another interim final regulation "establishing specific disproportionate share hospital payment requirements." 56 Fed. Reg. 56141, 56143 (1991).

2. Respondent Temple operates Temple University Hospital, the largest provider of hospital services under the Pennsylvania Medicaid Program. The area of North Philadelphia surrounding Temple University Hospital is

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[6] This amendment was enacted after the decision of the District Court. The Court of Appeals was advised of the change by letter from Respondents' counsel under Federal Rule of Appellate Procedure 28(j). Although they do so here, Petitioners did not rely on this amendment in their briefs or argument to the Court of Appeals.

largely black and hispanic and has a substantial indigent population. About half the admissions to Temple University Hospital are eligible for Medicaid, another twenty percent (also largely indigent) are covered by Medicare, and about five percent have no source of payment whatsoever. Temple University Hospital deals with all of the severe health problems of the poor neighborhoods in American cities, including the effects of crime, drug addiction, and untreated medical conditions. In each of the five fiscal years from 1985 through 1989, Temple lost between $2.5 and $7.5 million treating Medicaid inpatients. Temple achieved some cross-subsidization from treating non-Medicaid patients but still lost $3.2 million on inpatient care in fiscal 1989. Temple incurred these losses notwithstanding that it was, as the District Court found, efficiently and economically operated. (Pet. App. 65a). Temple University Hospital is a classic example of the "disproportionate share" hospital which the requirements of the Medicaid Act were intended to protect. It is heavily dependent on the adequacy of payments under the Pennsylvania Medicaid Program.

3. In August of 1988, Respondent Temple brought an action in the United States District Court for the Eastern District of Pennsylvania alleging that the payment rates for inpatient hospital care under the Pennsylvania Medicaid Program violated both of the above requirements of the Medicaid Act. The other hospitals that are Respondents in this Court brought separate actions in November and December of 1988 raising substantially similar issues. The subsequent cases were assigned to the same District Judge as Temple's action but

have never been consolidated with that action in the District Court.

4. Temple's action was tried in June of 1989 and decided by the District Court in January of 1990. In a series of rulings, the District Court found that Petitioners had made no real effort to comply with the procedural requirements of the Medicaid Act and that the payments for inpatient hospital care violated that Act. The principal rulings were:

> (a) The rate levels were not "reasonable and adequate" to meet the necessary costs of efficient hospitals but "entirely budget-driven" and "arbitrary" (Pet. App. 78a);
>
> (b) Petitioners established the amount of the additional payments to "disproportionate share" hospitals by allocating the funds deemed available for that purpose. The additional payment to Temple was "only a small fraction of the total increase in costs attributable to Temple's status as a disproportionate-share hospital" (Pet. App. 79a, 80a); and
>
> (c) Petitioners merely certified to the Secretary of Health and Human Services that the rates complied with the Medicaid Act without making any empirical studies to support the assurances (Pet. App. 84a-85a).

5. Based on these and related findings, the District Court issued an injunction directing the Petitioners to bring their Program into compliance. The District Court was careful not to insist that Petitioners establish any particular rate structure, but did direct them to increase cash payments to Temple pending revision of the Program. The District Court also directed Petitioners to

increase payments to other Respondents pending revision of the Program to the extent that the reason for the increased payments to Temple applied "to all hospitals, without regard to their classification or other individual distinguishing characteristics." (Pet. App. 105a, 107a, 109a, 111a).[7] These increased payments were subject to repayment (or offset against future payments) if the hospitals were not entitled to them under the revised Medicaid Program.

6. Petitioners appealed each of these Orders. After consolidating the appeals, the Third Circuit affirmed the orders of the District Court in all respects. The Third Circuit emphasized that Petitioners had conducted no analysis to determine the reasonableness or adequacy of these rates and no analysis to determine the effect on a hospital of the disproportionate add-on payments. (Pet. App. 25a-26a). The Third Circuit relied on the testimony of Petitioners' principal trial witness that they did not "know, today, what hospital costs are" and concluded that, since Petitioners had no knowledge of hospital costs, their assurances of their compliance with the Medicaid Act were "without foundation." (Pet. App. 26a-27a).

7. Before decision by the Third Circuit, the parties entered into a Stipulation of Settlement under which they agreed to settle any dispute over payments for the effective period of the Stipulation, to place the actions in the District Court in civil suspense and to engage in a series

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[7] The other Respondents still have applications for relief pending in the District Court.

of pooling transactions[8] to enable Petitioners to pay higher rates. The parties believe that pooling transactions already completed will enable Petitioners to pay the higher rates, and will enable the Stipulation of Settlement to remain in effect, until June 30, 1992. The Stipulation provides that, if the parties can continue to engage in pooling transactions so that the Stipulation remains in effect until July 1, 1993, they will then dismiss each of the actions pending in the District Court.

8. On October 28, 1991, Petitioners filed this Petition seeking review of the decision of the Court of Appeals.

REASONS WHY THE PETITION SHOULD BE DENIED

I. INTRODUCTION AND SUMMARY

Respondent Temple brought this action to challenge the particular method by which Pennsylvania established its Medicaid rates for Temple University Hospital, an inner-city medical school hospital with the state's highest Medicaid volume. The lower courts were constrained to rule in Temple's favor by Pennsylvania's failure to make even a good faith effort to comply with the Medicaid Act and by the resulting discrepancies between Pennsylvania's Program and that Act. The District Court granted limited relief to the other Respondent hospitals because

[8] A pooling transaction allows the use of private donated funds as the State's share of Medicaid payments as permitted by 42 C.F.R. § 433.45(b).

the discrepancies applied in part "to all hospitals, without regard to their classification or other individual distinguishing features." (Pet. App. 105a, 107a, 109a, 111a).

Now, in an effort to find some question deserving of this Court's attention, Petitioners urge this Court to reconsider and overrule its recent decision in *Wilder v. Virginia Hospital Association*, 110 S. Ct. 2510 (1990). There is no special justification for such action. In any event, this case would present a poor vehicle for such action, given: (1) Petitioners' total failure to comply with the procedural requirements of the Medicaid Act; (2) the peculiar issues presented by the application of the Medicaid Act and the Pennsylvania Program to Temple; and (3) the possibility that these actions may be dismissed pursuant to a Stipulation of Settlement among the parties.

To their request to reconsider and overrule *Wilder*, Petitioners add a question concerning the requirement of the Medicaid Act for "disproportionate share" hospitals. This second question is of such limited application as to be unworthy of this Court's attention.

II. THERE ARE NO SPECIAL CIRCUMSTANCES TO WARRANT THIS COURT REEXAMINING ITS INTERPRETATION OF THE MEDICAID ACT.

The Petition asks this Court to reconsider its holding of less than two years ago, in *Wilder v. Virginia Hospital Association*, that health care providers have the right under 42 U.S.C. § 1983 to seek injunctive relief against State officers to enforce the Medicaid Act. The Petition argues that *Wilder* should be reconsidered and overruled because: (1) *Wilder* has begun to "unleash" a "torrent" of

provider challenges to state Medicaid programs; (2) it subjects state Medicaid rates to multiple attacks in multiple fora; and (3) *Wilder* was incorrectly decided.

This Court has held that " 'any departure from the doctrine of *stare decisis* demands special justification.' " *Patterson v. McLean Credit Union*, 109 S. Ct. 2363, 2370 (1989) (*quoting Arizona v. Rumsey*, 467 U.S. 203, 212 (1984)).

> We have said also that the burden borne by the party advocating the abandonment of an established precedent is greater where the Court is asked to overrule a point of statutory construction. Considerations of *stare decisis* have special force in the area of statutory interpretation, for here, unlike in the context of constitutional interpretation, the legislative power is implicated, and Congress remains free to alter what we have done.

Patterson, 109 S. Ct. at 2370. There is no special justification for departing from this Court's holding in *Wilder* so shortly after it was decided.

Contrary to the Petition, *Wilder* has not "unleashed" a "torrent" of provider actions challenging Medicaid payment rates. Rather, the evidence is that provider actions have decreased since *Wilder*. Pennsylvania and forty-five other states argued in *Wilder* that decisions by the Courts of Appeals had resulted in an "explosion" of litigation, pointing to thirty-one actions then pending against eighteen states.[9] In the present Petition, Pennsylvania points to

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[9] Brief Amici Curiae of the States of Connecticut, et al. at vii and Appendix, *Wilder*.

only thirteen actions against nine states.[10] At a time when more than twice as many actions were pending, this Court in *Wilder* considered and rejected the argument that allowing Medicaid providers to enforce State obligations under the Medicaid Act would burden the courts and the States with numerous challenges to Medicaid rates.[11] The few actions cited in the Petition do not constitute special circumstances that would warrant reconsideration of *Wilder.*

The Petition also argues that *Wilder* should be reconsidered because it subjects State Medicaid rates to multiple attacks in multiple fora. The Petition does not, however, identify any method of attack or any forum that has become available since *Wilder.* Review by the Secretary of Health and Human Services is not effective since, as the parties stipulated in this case, the Secretary does not normally look behind the findings and assurances given by the State. The Secretary normally accepts them at face value. Review in State administrative proceedings is similarly ineffective:

> The regulations allow States to limit the issues that may be raised in [a State] administrative proceeding. 42 C.F.R. § 447.253(c) (1989). Most States . . . do not allow health care providers to

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[10] In counting the number of pending actions cited in the list of the amici in *Wilder* and in the list in the Petition, we have included the five actions before this Court on this Petition.

[11] The number of Medicaid lawsuits is probably decreasing because the courts have accorded substantial deference to the States in developing Medicaid payment systems. *See, e.g., Wilder,* 110 S. Ct. at 2523 n.18.

> challenge the overall method by which rates are determined.

Wilder, 110 S. Ct. at 2524-25.[12] An action in federal court is a health care provider's only remedy for a State violation of the Medicaid Act. States are not subject to multiple attacks in multiple fora; rather, if *Wilder* is reversed, State Medicaid rates will be wholly insulated from provider challenges.

Since *Wilder* was decided less than eighteen months ago, Congress has amended the Medicaid Act as part of the Omnibus Budget Reconciliation Act of 1990. In amending the Medicaid Act, Congress declined the opportunity to nullify or alter *Wilder*. Similarly, there has been no intervening development of the law which has removed the conceptual underpinnings of *Wilder*, no new doctrines or policies that compete with *Wilder*, no evidence that *Wilder* is unworkable, and no evidence that it is an obstacle to important legal objectives. There is no reason to depart from the doctrine of *stare decisis*. *See Patterson*, 109 S. Ct. at 2370-71.

Petitioners argue at length that *Wilder* was decided incorrectly. *Wilder* was decided correctly and we will not reargue it in this Brief. We will point out, however, that even if the Court were prepared to overrule *Wilder*, it

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[12] Pennsylvania's administrative procedure does not afford providers the right to challenge Pennsylvania's payment methodology. *W. Va. Univ. Hosps., Inc. v. Casey*, 885 F.2d 11, 30 (1989), *cert. granted and aff'd on different issue*, 111 S. Ct. 1138 (1991).

would not necessarily reverse the decision of the Court of Appeals as to Temple for at least two reasons:

1. The plaintiffs in *Wilder* alleged only that Virginia's rates were not "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." Temple makes the additional claim that Pennsylvania's rates violate the requirement that the rates adequately "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs" as set forth in 42 U.S.C. § 1396a(a)(13)(A) and expanded by Congress in 42 U.S.C. § 1396r-4. If this Court were to overrule *Wilder*, holding that providers may enforce the requirement that rates be "reasonable and adequate" to meet the necessary costs of efficient providers, it would still have to decide whether a hospital can enforce the "disproportionate share" requirement. Congress has repeatedly focused on the financial needs of "disproportionate share" hospitals, even to the point of enacting an additional section for their benefit. Moreover, the Medicaid Act directly requires rates to take the situation of "disproportionate share" hospitals into account, not merely that the State make findings and assurances. Even if the Court were to overrule *Wilder*, it might well permit a "disproportionate share" hospital to bring an action under 42 U.S.C. § 1983.[13]

2. The plaintiffs in *Wilder* alleged only that Virginia's rates violated the substantive standards of the

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[13] For the reasons stated below, we do not believe that the "disproportionate share" hospital requirement is worthy of this Court's attention.

Medicaid Act. Temple makes the additional claim that Petitioners violated the procedural requirements of the Medicaid Act by making no analysis of hospital costs. Indeed, the Court of Appeals held that Pennsylvania's findings and assurances to the Secretary were "without foundation." (Pet. App. 27a). Even if this Court were to reverse *Wilder* by holding that a provider has no right under 42 U.S.C. § 1983 to require compliance with the substantive requirements of the Medicaid Act, it would then have to decide whether a provider has the right to compel a State to establish rates based on bona fide findings and assurances.

III. THE HOLDINGS OF THE COURTS BELOW ON THE DISPROPORTIONATE SHARE HOSPITAL REQUIREMENT ARE BASED ON FACTS PECULIAR TO PENNSYLVANIA AND TO RESPONDENT TEMPLE.

The "disproportionate share" requirement in the Medicaid Act applies to a relatively small number of hospitals, is rarely invoked in hospital litigation against Medicaid payment rates, has been only rarely interpreted by the courts, and is still being refined by Congressional and regulatory action. The findings of the courts below were based on facts peculiar to Pennsylvania and to Temple. The holding of the Court of Appeals on the "disproportionate share" hospital requirement does not warrant attention by this Court.

As demonstrated above, Congress has repeatedly expressed its concern for the manner in which the States have elected to deal with the situation of high-volume

Medicaid hospitals. Repeated Congressional actions have established both that Congress recognized the special role that inner city hospitals with high Medicaid volumes play in delivering health care to the poor and that Congress intended States to assure the survival of these hospitals by making substantial additional payments to them.

The "disproportionate share" requirements have, however, not been the subject of extensive litigation in the federal courts. Petitioners can show no conflict among the Circuits. The decision of the Third Circuit in Temple's action is the only decision by a Court of Appeals on the substance of the "disproportionate share" hospital requirement.[14] That requirement has been the subject of little litigation because States are required to make these payments to only a small percentage of hospitals.[15] Thus, although Congress expressed particular concern for the treatment of "disproportionate share" hospitals, that concern has not been the subject of any substantial amount of litigation and should not warrant review by this Court.

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[14] The only other decision by a Court of Appeals is *West Virginia University Hospitals, Inc. v. Casey*, 885 F.2d 11 (3d Cir. 1989), *cert. granted and aff'd on different issue*, 111 S. Ct. 1138 (1991), in which the Third Circuit held that Pennsylvania could not deny "disproportionate share" status to an out-of-state hospital that qualified under the standards applied to in-state hospitals. *West Virginia* did not address the level of payments required for "disproportionate share" hospitals.

[15] In contrast, the Medicaid Act requires States to make payments that are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" to all participating hospitals, as well as all nursing and intermediate care facilities.

The Petition attacks the opinion of the District Court for imposing on Pennsylvania a requirement applicable to all hospitals that is not included in the Medicaid Act and not supported by any legislative history of that Act.[16] The Petition ignores the fact that the District Court has so far applied its "disproportionate share" holding to only one hospital. The Petition also ignores the facts, unique to Pennsylvania and to Respondent Temple, which form the basis of the District Court's holding:

1. Petitioners established the amount of the payments to "disproportionate share" hospitals without any consideration or analysis of the needs of, or additional costs incurred by, these hospitals. (Pet. App. 80a.) Thus, Petitioners made no bona fide attempt to comply with the Medicaid Act. Their assurances that the rates complied with the "disproportionate share" hospital requirement were "without foundation." (Pet. App. 27a).

2. Pennsylvania's additional payment to those hospitals with the highest Medicaid utilization was only 2.5%. Petitioners' own expert at trial calculated the additional costs of those hospitals as at least 16% above comparable hospitals. (Pet. App. 79a, 80a). The Medicaid add-on would have provided an additional payment of about

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[16] The Petition also argues that the District Court should have given great deference to HCFA's approval of Pennsylvania's "disproportionate share" payment plan. Neither the District Court nor the Court of Appeals could have done so because that approval, if it occurred, was never included in the record of this proceeding. This Court does not permit arguments based on facts outside the record. *Witters v. Wash. Dept. of Servs. for the Blind*, 474 U.S. 481, 486 n.3 (1986); *New Haven Inclusion Cases*, 399 U.S. 392, 450 n.66 (1970).

21% to one of those hospitals, Respondent Temple. (Pet. App. 82a). Thus, there was an enormous gap between what Pennsylvania provided and what objective analysis or the Medicare formula would have provided. The gap was so large it could not be upheld under *any* construction of the Medicaid Act.

Based on these facts and mindful that States are given "a considerable amount of flexibility" in this area, the District Court nonetheless concluded that "Pennsylvania's adjustment for [Temple's] disproportionate-share status misses the mark by so wide a margin as to be inconsistent with the intent of Congress." (Pet. App. 82a). The District Court has not yet extended this holding to other hospitals in Pennsylvania.[17]

In summary, the holdings of the Courts below on the "disproportionate share" hospital requirement relate only to the particular facts of a single State and of the hospital with the highest Medicaid volume within that State. The requirement is still in the process of legislative clarification and regulatory interpretation and has only rarely been the subject of litigation. The issue presented by the Petition does not warrant review by this Court.

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[17] Other Respondent hospitals applied to the District Court for relief on the "disproportionate share" hospital requirement in early 1990. Those applications remain pending.

CONCLUSION

The actions before the Court are the subject of a Stipulation of Settlement which places them in civil suspense in the District Court and makes them subject to possible dismissal on July 1, 1993. As a result, any action by this Court may have no effect on the underlying litigation. In addition, the Petition presents no special circumstances why this Court should reconsider its decision in *Wilder v. Virginia Hospital Association*. For these and the other reasons stated in this Brief, this Court should deny the Petition for Writ of Certiorari.

Dated: November 29, 1991

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